Consumer Directed Services (CDS) Option

Comprehensive Nursing Assessment and Plan of Care — HCS Program

To be performed by a Registered Nurse (RN)

Individual's Name	Date of Birth	Today's Date

I. Review

Members of the Individual's Health Care Team

	Health Care Practitioners	Date Last Seen	Comments
Primary care			
Psychiatrist			
Neurologist			
Dentist			
Optometrist			

Natural Supports	Relationship	Telephone Number

Health History

History of major medical/surgical occurrences:

Other:

RN _____

Individual: _____ Date: _____

Review of Current Medications (include OTCs, vitamins and herbs)					
Allergies:					
Medication	**Dose**	**Frequency**	**Route**	**Purpose/Rationale**	**Side Effects/Labs**

RN: _____

Individual: _____ Date: _____

II. Current Status

Current medical and psychiatric history

Briefly describe recent changes in health or behavioral status, hospitalizations, falls, seizure activity, restraints, etc., within the past year.

What is of primary concern to/are the greatest expressed needs of the individual, legally authorized representative (LAR) or client's responsible adult (CRA) from the person's own perspective?

Vital Signs

Blood pressure	Pulse Rate _____ Rhythm _____	Respirations Rate _____ Rhythm _____

Temperature	Pain level	Weight	Height

Comments:

Fall Risk Assessment

Has a fall risk assessment been completed?

- ☐ No
- ☐ Yes (attached). Fall risk is due to:
  - ☐ Neurological
  - ☐ Musculoskeletal
  - ☐ Unknown

Comments:

RN: _____

Individual: _____ Date: _____

III. Review of Systems

Neurological

	Y	N		Y	N		Y	N
Headaches	☐	☐	Pupils equal and reactive to light and accommodation	☐	☐	Tremors	☐	☐
Dizziness	☐	☐	Tremors	☐	☐	Heat/cold reflex	☐	☐
Impaired balance/ coordination	☐	☐	Numbness/tingling/ paresthesia	☐	☐	Extrapyramidal symptoms	☐	☐
Medication side effects	☐	☐	Paralysis	☐	☐			
	Y	**N**		**Y**	**N**		**Y**	**N**
Seizures	☐	☐	Petit mal	☐	☐	Clonic (repetitive jerking)	☐	☐
Frequency: _____			Absence	☐	☐	Tonic (muscle rigidity)	☐	☐
Duration: _____			Myoclonic (sporadic jerking)	☐	☐	Atonic (loss of muscle tone)	☐	☐

Comments:

Eyes, Ears, Nose and Throat

Eyes/Vision
☐ Clear ☐ Red ☐ Right impaired ☐ Left impaired ☐ Adaptive aid

Ears/Hearing
☐ Normal ☐ Ringing ☐ Right impaired ☐ Left impaired ☐ Adaptive aid

Nose/Smell
☐ Within normal limits Smell: ☐ intact ☐ not intact ☐ Nose bleeds ☐ Frequent sinus congestion
☐ Frequent sinus infection

Oral
☐ Within normal limits ☐ Difficulty chewing ☐ Mouth pain ☐ Halitosis ☐ Dentures ☐ Edentulous
☐ Involuntary tongue movement ☐ Dry mouth from meds

Throat
☐ Within normal limits ☐ Sore throats ☐ Difficulty speaking ☐ Difficulty swallowing ☐ Tonsil enlargement
☐ History of choking ☐ Thyroid enlargement

Swallow study: ☐ **Yes** ☐ **No** Date: _____ Results: _____

Comments:

Cardiovascular

	Y	N		Y	N		Y	N
Edema	☐	☐	Cool/numb extremities	☐	☐	Capillary refill less than or equal to 2 seconds	☐	☐
Chest pain	☐	☐	Activities of daily living (ADL) limitations	☐	☐	Compression stocking	☐	☐
High/low blood pressure	☐	☐						

Normal range: _____

Comments:

RN: _____

Individual: _____ Date: _____

Gastrointestinal

☐ Gastrostomy ☐ Jejunostomy ☐ No tube

Bowel sounds	Last bowel movement	Bowel habits (frequency and description)

	Y	N		Y	N		Y	N
Continent	☐	☐	Reflux	☐	☐	History of risk constipation	☐	☐
Frequent nausea	☐	☐	Straining pain	☐	☐	History of risk impaction	☐	☐
Frequent vomiting	☐	☐	Diarrhea	☐	☐	Bowel program	☐	☐
Indigestion	☐	☐	Odd stools	☐	☐	Medications influencing bowels (laxatives, antidiarrheals, iron, calcium, anticholinergics, etc.)	☐	☐
Heartburn	☐	☐	Hemorrhoids	☐	☐			
Appetite loss	☐	☐	Independent toileting	☐	☐			

Comments:

Respiratory

Breathing: ☐ Slow ☐ Normal ☐ Rapid ☐ Shallow ☐ Painful

	Y	N		Y	N		Y	N
Short of breath	☐	☐	Feeding tube	☐	☐	Tracheostomy	☐	☐
Wheezing	☐	☐	Positioning orders	☐	☐	Continuous positive airway pressure (CPAP)	☐	☐
Fatigue	☐	☐	Aspiration history	☐	☐	Inhalation agent	☐	☐
Cough	☐	☐	Pneumonia history	☐	☐	Oxygen @ _____	☐	☐
Productive	☐	☐						

Comments:

Musculoskeletal

	Y	N		Y	N		Y	N
Pain	☐	☐	Prosthesis	☐	☐	Impaired range of motion	☐	☐
Weakness	☐	☐	Deformity	☐	☐	Impaired gait	☐	☐
Stiffness	☐	☐	Contractures	☐	☐	Adaptive equipment	☐	☐

Comments:

RN: _____

Individual: _____ Date: _____

Genitourinary

	Y	N		Y	N		Y	N
Incontinent	☐	☐	Flank pain	☐	☐	Sexually active	☐	☐
Stress	☐	☐	History of urinary tract infections	☐	☐	Prostate issues	☐	☐
Urge	☐	☐	Noctouria	☐	☐	Menstrual cycle regular	☐	☐
Bladder program	☐	☐	Discharge	☐	☐	Date of last menstrual period: _____		
Frequent urination	☐	☐	Itching	☐	☐			
Cloudy/dark urine	☐	☐	Hemodialysis	☐	☐	Menopausal	☐	☐
Bloody urine	☐	☐	Peritoneal dialysis	☐	☐	If yes, date of onset: _____		

Comments:

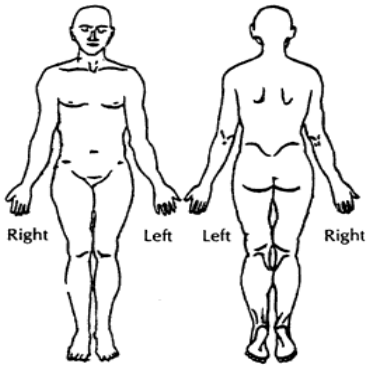
Integumentary

Skin assessment: ☐ Attached ☐ Deferred

Skin: ☐ Normal ☐ Moist ☐ Dry ☐ Cyanotic ☐ Warm ☐ Pale ☐ Jaundice ☐ Cold ☐ Dusky ☐ Flushed

	Y	N		Y	N		Y	N
Open wound	☐	☐	Rash	☐	☐	Blemished	☐	☐
Bruising	☐	☐	Diaphoretic	☐	☐	Poor skin turgor	☐	☐
Breakdown related to adaptive aids/prosthesis	☐	☐	Risk for breakdown	☐	☐	History of breakdown	☐	☐

Comments:



RN: _____

Individual: _____ Date: _____

Endocrine

	Y	N
Thyroid dysfunction.....	☐	☐
Atypical antipsychotics or other medications affecting blood sugar.....	☐	☐
Pre-diabetic hypoglycemic/ hyperglycemic episodes.....	☐	☐

	Y	N
Diabetes	☐	☐

If yes, type: _____

Management: ☐ Diet ☐ Oral medications
☐ Insulin ☐ Other injectable medication to manage diabetes:

_____

Desired blood sugar ranges: _____

Comments:

IV. Additional Health Status Information

Immunizations: Date last received

DPT	TOPV	HIB	MMR	TD	TDS	Flu shot

Nutritional Assessment

How nutrition is received: ☐ Orally ☐ Via jejunostomy tube
☐ Via gastrostomy tube if residual: _____ ☐ Other

Therapeutic diet: _____ Liquid consistency: _____

Food texture: _____ Reason/date/ordered by: _____

	Y	N
Recent weight change	☐	☐
Recent changes in appetite/medication	☐	☐
Satisfied with current weight	☐	☐
Food use as a coping mechanism	☐	☐
Assistive devices with eating	☐	☐
Use of medications that can cause difficulty swallowing (e.g., Abilify, other psychoactives)	☐	☐
Knowledge of four basic food groups.....	☐	☐
Access to healthy/appropriate diet.....	☐	☐
Dietary deficiencies.....	☐	☐
Adequate fluid intake	☐	☐
Nutritional supplements	☐	☐
Interactions with meds and food	☐	☐

_____ lbs. ☐ gain ☐ loss over _____

Desired weight range: _____

Number of meals/snacks per day: _____

Comments:

Sleep Patterns

Average number of hours per night; difficulty falling asleep; number of times awake at night; number of naps during a day:

Activity Level/Exercise

Substance Use/Abuse

Caffeine, tobacco, alcohol, recreational drugs, history of noncompliance with prescribed medications:

RN: _____

Mental Status

Appearance

Posture: ☐ Normal ☐ Rigid ☐ Slouched ☐ Other: _____

Grooming and dress: ☐ Appropriate ☐ Inappropriate ☐ Disheveled ☐ Neat

Facial expression: ☐ Calm ☐ Alert ☐ Stressed ☐ Perplexed ☐ Tense ☐ Dazed ☐ Other: _____

Eye contact: ☐ Eyes not open ☐ Good contact ☐ Avoids contact ☐ Stares

Speech quality: ☐ Clear ☐ Slow ☐ Slurred ☐ Loud ☐ Rapid ☐ Incoherent ☐ Mute

Mood

☐ Cooperative	☐ Uncooperative	☐ Depressed	☐ Euphoric
☐ Excited	☐ Agitated	☐ Anxious	☐ Suspicious
☐ Irritable	☐ Scared	☐ Hostile	☐ Angry

☐ Other/describe: _____

Cognition

	Y	N
Cognitive impairment		
Mild	☐	☐
Moderate	☐	☐
Severe	☐	☐
Profound	☐	☐
Memory		
Remote	☐	☐
Recent	☐	☐
Immediate recall	☐	☐

	Y	N
Oriented		
Person	☐	☐
Place	☐	☐
Time	☐	☐

	Y	N
Attention span		
Easily distracted	☐	☐

Emotions

	Y	N
Euphoric	☐	☐
Happy	☐	☐
Apathetic	☐	☐
Sadness	☐	☐

	Y	N
Depressed	☐	☐
Anxious	☐	☐
Irritable	☐	☐

	Y	N
Hostile feelings	☐	☐
Emotional lability	☐	☐
Inappropriate affect	☐	☐

Individual: _____ Date: _____

Thoughts

	Y	N		Y	N		Y	N		Y	N
Delusions	☐	☐	Hallucinations	☐	☐	Thought process	☐	☐	Thought content	☐	☐
If yes:			If yes:			If yes:			If yes:		
Grandeur	☐	☐	Visual	☐	☐	Coherent organized	☐	☐	Phobias	☐	☐
Persecutory	☐	☐	Auditory	☐	☐	Logical	☐	☐	Hypochondria	☐	☐
Somatic	☐	☐	Tactile	☐	☐				Antisocial urges	☐	☐
Other	☐	☐	Olfactory	☐	☐				Obsessions	☐	☐
									Suicidal ideations	☐	☐
Comments:									Homicidal ideations	☐	☐

Challenging Behaviors

Are medications used to control any behaviors? ☐ **Y** ☐ **N** Currently has a formal behavior plan? ☐ **Y** ☐ **N**

Use the following scales below for frequency and severity:

For frequency: 1 = less than once per month; 2 = 1 to 3 x month; 3 = 1 to 6 x week; 4 = 1 to 10 x day; and 5 = 1 or more x hour.

For severity: 1 = mild; 2 = moderate; 3 = severe; and 4 = critical.

	Frequency	Severity	Last Exhibited
Hurtful to self	_____	_____	_____
Hurtful to others	_____	_____	_____
Destructive to property	_____	_____	_____
Pica	_____	_____	_____
Resists car	_____	_____	_____
Socially offensive/disruptive behavior	_____	_____	_____
Sexually inappropriate behavior	_____	_____	_____
At risk behavior, such as:			
Wandering	_____	_____	_____
Elopement	_____	_____	_____
Sexually aggressive behavior	_____	_____	_____
History of suicide attempt	_____	_____	_____
Other serious behavior	_____	_____	_____

Comments:

RN: _____

Individual: _____ Date: _____

Communication

Primary language: _____

Mark ways that the individual commonly communicates:

	Y	N		Y	N		Y	N
Verbal	☐	☐	Facial expressions	☐	☐	Touch	☐	☐
Limited verbal	☐	☐	Eye movement	☐	☐	Body language	☐	☐
Gestures	☐	☐	Paralinguistics (sounds)	☐	☐	Acting out	☐	☐
Sign language	☐	☐	Augmented communication device	☐	☐	Head banging	☐	☐
			If yes, device type: _____			Other behaviors (describe): _____	☐	☐

Mark ways that pain is communicated:

	Y	N		Y	N		Y	N
Verbal	☐	☐	Facial expressions	☐	☐	Touch	☐	☐
Limited verbal	☐	☐	Eye movement	☐	☐	Body language	☐	☐
Gestures	☐	☐	Paralinguistics (sounds)	☐	☐	Acting out	☐	☐
Sign language	☐	☐	Augmented communication device	☐	☐	Head banging	☐	☐
Able to use pain scale	☐	☐	If yes, device type: _____			Other behaviors (describe): _____	☐	☐

If able to use pain scale, list type/name of pain scale:

Comments:

Individual: _____ Date: _____

V. Implementation Assessment

Health Care and Decision Making Capacity

The preceding review of functional capabilities, physical and cognitive status, and limitations indicate this individual's highest level of ability to make health care decisions.

☐ Probably can make higher level decisions (such as whether to undergo or withdraw life sustaining treatments that require understanding the nature, probable consequences, burdens and risks of proposed treatment).

☐ Probably can make limited decisions that require simple understanding, able to direct own health care, including delegated tasks.

☐ Probably can express agreement with decisions proposed by someone else.

☐ Cannot effectively participate in any kind of health care decision making.

RN: _____

Individual: ______________________ Date: ________________

Support Systems: Discuss the adequacy, reliability, availability and ability to communicate effectively.

	Adequate		Reliable		Available		Effective Communicator	
	Y	N	Y	N	Y	N	Y	N
CRA/Parent	☐	☐	☐	☐	☐	☐	☐	☐
Host Home or Companion Care (HH/CC) Provider	☐	☐	☐	☐	☐	☐	☐	☐
Guardian/Other	☐	☐	☐	☐	☐	☐	☐	☐

Stability and Predictability and Need to Reassess

Health Topic	Is a long-term need non-fluctuating consistent?		Status change possible, or likely to need regular nursing care?		Frequency of RN Reassessment
	Y	N	Y	N	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

Knowledge: Describe key health understandings/demonstrations.

Health Topic		Individual			CRA		
		Y	N	N/A	Y	N	N/A
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐

Comments:

RN: ______________________

Participants in Comprehensive Assessment
(Must complete section A, B or C, and Registered Nurse section.)

Option A: In this situation, the individual does not have a guardian/LAR and is able to make decisions regarding health care.

To be completed by the individual:

☐ I have participated in decisions about the overall management of my health care [Texas Administrative Code, Title 22, Part 11, Chapter 225, §225.1(a)(2)], can make all of my own decisions, am able to direct my own health care, and

☐ will not be directing health maintenance activities (HMAs) [§225.8(2)(D)(i)],

Or

☐ agree to train CDS unlicensed personnel in the performance of tasks listed on Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services.

Printed Name _____ Signature _____ Date _____

Option B: In this situation, the individual cannot make decisions regarding health care or has asked for assistance.

To be completed by the CRA/LAR:

☐ I have participated in decisions about the overall management of health care. [§225.1(a)(2)]

☐ I will be participating in decisions only, not directing care. No HMAs will be performed.

Or

☐ I agree to train CDS unlicensed personnel in the proper performance of tasks identified on Form 1733, and I will be present when the task is performed or, if not present, will have observed the unlicensed person perform the task and will be immediately accessible in person or by phone to the assistive personnel when the task is performed. [§225.8(2)(D)(ii)(I-II)]

Printed Name _____ Signature _____ Date _____

Option C: In this situation, the individual cannot make decisions regarding health care and does not have a single identified adult who is willing and able to participate in decisions about the overall management of the individual's health care. [§225.1(a)(2)]

☐ Provider Advocate Committee (PAC) will act as the CRA (form attached).

Safe Administration of Medications
A comprehensive review of functional capabilities, physical and cognitive status, limitations, and natural supports rate this individual's ability to take his/her own medications in a safe and appropriate manner according to the five Rights of Medication Administration (correct person, medication [what, why], dose, time, route).

RN Delegation Worksheet ☐ Attached ☐ N/A

☐ **Self-administration of medication.** Individual knows how to safely take each medication (what, why) and the dose, route and time of each medication. The individual is competent to safely self-administer medications independently or independently with ancillary aid provided to the individual in the individual's self-administered medication treatment or regimen, such as reminding an individual to take a medication at the prescribed time, opening and closing a medication container, pouring a predetermined quantity of liquid to be ingested, returning a medication to the proper storing area, and assisting in reordering medications from a pharmacy. **No RN Delegation is necessary.** [§225.1(a)(3)]

☐ **Administration of medication to an individual by a paid unlicensed person(s) to ensure that medications are received safely.** Administration of medications includes removal of an individual/unit dose from a previously dispensed, properly labeled container; verifying it with the medication order; giving the correct medication and the correct dose to the proper individual at the proper time by the proper route; and accurately recording the time and dose given. [§225.4(2)]. Check all that apply:

☐ **CRA can safely direct as an HMA. No RN delegation is necessary.** The individual has a single identified CRA whose knowledge, abilities and availability qualifies the administration of oral meds (by mouth or through a permanently placed feeding tube) as an HMA exempt from delegation and is appropriate per RN judgment. Medications may be administered for stable and predictable conditions (not initial doses and/or for acute conditions) without RN supervision provided that the CRA is willing, able and agrees in writing to train the unlicensed person(s) in performing the task at least once to assure competence and will be immediately accessible in person or by telecommunications to the unlicensed person(s) when the task is performed. [§225.4(8), §225.8]

☐ **RN delegation necessary to ensure safe medication administration.** The RN can safely authorize unlicensed personnel to administer medications for stable and predictable conditions as defined in §225.4(11) not requiring nursing judgment. Competency of each assistive personnel, including the ability to recognize and inform the RN of client changes related to the task, must be verified by the RN. The six rights of delegation (the right task, the right person to whom the delegation is made, the right circumstances, the right direction and communication by the RN, the right supervision, and the right documentation) and all criteria at §225.9 must be met. CRA lacks knowledge, abilities and/or availability per §225.8 to direct as an HMA. Individual (if competent), CRA (if one exists) or PAC must approve the decision of the RN to delegate tasks, in writing. See delegation criteria at §225.9, §225.10.

Routes that may be delegated:

☐ **The RN has determined that delegation is not required because the parent/LAR can assume responsibility and accountability for the individual's health care.** The RN has considered the length of time the individual has been living in the home, the relationship of the individual and foster care provider, and the supports available to the foster care provider, and has determined that the foster care provider can safely assume this responsibility. The RN will serve as a resource, consultant or educator, and will intervene when necessary to ensure safe and effective care. [§225.6(a)(3)] Documentation of subsequent interventions, including when additional follow-up is needed, will be a part of the RN's nursing care plan.

☐ **The RN has determined that delegation is not required for oral, topical and metered dose inhalers**. The RN has determined that the medications not being delegated to paid unlicensed staff are for a stable or predictable condition. The RN or Licensed Vocational Nurse (LVN), under the direction of an RN, has trained and determined the paid unlicensed staff's competency. [Texas Human Resources Code, Title 11, Chapter 161, Subchapter D]

☐ **Must be administered by a licensed nurse.** Medications that **may not be delegated** are:

Nurse Supervision

Determine in consultation with the individual or CRA/LAR the level of supervision and frequency of supervisory visits, taking into account: the stability of the individual's status; the training, experience and capability of the CDS unlicensed staff to whom the nursing task is delegated; the nature of the nursing task being delegated; the proximity and availability of the RN to the unlicensed person when the task will be performed; and the level of participation of the individual or CRA. [§225.9(a)(3)(A-E)]

Name of unlicensed personnel: _____

List all who were consulted in determining the level of nurse supervision for the above-named unlicensed personnel:

- ☐ Individual
- ☐ CRA
- ☐ LAR
- ☐ PAC
- ☐ Other: _____

RN follow-up to monitor competency of CDS unlicensed personnel of the following delegated task(s):

_____

- ☐ Not applicable, no tasks are delegated
- ☐ Once additionally within the first _____ , then:
  - ☐ Monthly
  - ☐ Quarterly
  - ☐ Once additionally within the year
  - ☐ Annually
- ☐ Other: _____

Additional monitoring of CDS unlicensed personnel by an RN or LVN:

- ☐ Not applicable, no tasks are delegated
- ☐ Once additionally within the first _____ , then:
  - ☐ Monthly
  - ☐ Quarterly
  - ☐ Once additionally within the year

Notes:

VI. Plan of Care/Summary

Summary/Clinical Impressions

Strengths as related to health:

Consultations recommended:

Summary:

Nursing Service Plan of Care

Concerns/nursing diagnoses:

Intervention/strategies:

Implementation Strategy Objectives	Start Date	Target Completion	Calculation of Units (if applicable)	Total Units (per strategy)

Total Nursing Units Needed

RN	RN Specialized	LVN	LVN Specialized

Desired outcomes/goals:

Registered Nurse

I have developed this plan and retain accountability for any delegated tasks. Each CDS unlicensed personnel competency will be verified before allowing delegated tasks to be performed without direct nursing supervision. An RN will be immediately accessible by phone to the unlicensed personnel when the task is performed.

Printed Name _____ Signature _____ Date _____

Physician

Printed Name and Credentials _____ Signature _____ Date _____